Supreme Court, U.S.
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APPLICATION NUMBER A-474

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1993

THOMAS B. KEE, PETITIONER

vs.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY, RESPONDENT

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

THOMAS B. KEE, PRO SE

8475 SW 155th Terrace
Miami, Florida 33157
(305) 255 1000
Fax (305) 235 4532

75 pp

QUESTIONS PRESENTED FOR REVIEW AND BASIS FOR WRIT OF CERTIORARI

I. Whether a person's state of mind in responding to questions on an insurance policy application is critical to determining the issue of misrepresentation as it relates to the insurer's ability to rescind the policy within the contestability period?

II. Is a state statute which deals with the application of the incontestability clause to an insurance policy unconstitutionally vague on its face when it contains language critical to the determination of the expiration of the incontestability

period which is contradictory and confusing and a violation of the 14th Amendment to the United States Constitution?

TABLE OF CONTENTS

	PAGE
Questions presented for review [Supreme Court Rule 14(.1)(a)]	i
Table of contents [Supreme Court Rule 14(.1)(c)]	ii
Table of authorities [Supreme Court Rule 14(.1)(c)]	iii
Official and unofficial reports of opinions [Supreme Court Rule 14(.1)(d)]	iv
Grounds on which the jurisdiction of this Court is invoked [Supreme Court Rule 14(.1)(e)]	v
Constitutional provisions and statutes [Supreme Court Rule 14(.1)(f)]	vi
Statement of the case	vii

[Supreme Court Rule 14(.1)(g)]

Basis for federal jurisdiction viii
[Supreme Court Rule 14(.1)(i)]

Argument amplifying the reasons relied on for the allowance of the writ ix
[Supreme Court Rule 14(.1)(j)]

Concise Statement of the Case 1

Proceedings in Lower Court 20

Argument 23

Conclusion 42

Appendix

See Appendix
[Supreme Court Rule 14(.1)(k)]

TABLE OF AUTHORITIES
CASES

	PAGES
CONTINENTAL ASSURANCE CO. v. CARROLL, 485 So.2d 406 (Fla. 1986) and 459 So.2d 443 (Fla. App. 4 Dist. 1984)	27,28,29
GUARDIAN LIFE INSURANCE COMPANY v. SCHAEFER, 519 N.E. 2d 288 (NY 1987), 524 N.Y.S. 2d 377 (Ct. App. 1987)	12,13
HYMAN v. LIFE INSURANCE CO. OF NORTH AMERICA, 481 F2d 441 (1973)	26
LIFE INSURANCE COMPANY OF VIRGINIA v. SHIFFLET, 201 So.2d 715 (Fla. 1967)	26,27,28,29,32

NATIONAL STANDARD
LIFE INSURANCE
COMPANY v. PERMENTER,
204 So.2d 206
(Fla. 1967)

27

SKINNER v. AETNA
LIFE AND CASUALTY,
804 F2d 148 (D.C.
Cir. 1986)

30,41

STATE FARM FIRE
AND CASUALTY CO.
v. OLIVER, 854 F.2d
416 (11th Cir.1988)

31

WILLIAM PENN LIFE
INSURANCE CO. OF
NEW YORK v. SANDS,
912 F2d 1359 (11th
Cir. 1990)

28,29,30,31,36,38

Blacks Law Dictionary

Supreme Court Rule 14(.1)(d)

OFFICIAL AND UNOFFICIAL REPORTS OF OPINIONS

For official and unofficial reports of opinions delivered in the case by other courts:

Please see Appendeix for previous opinions on this case and the table of authorities (citations of case law) on which Petitioner relies.

Supreme Court Rule 14(.1)(e)

GROUNDS ON WHICH THE JURISDICTION OF THIS COURT IS INVOKED

Supreme Court Rule 14(.1)(e) response:

(i) The date of entry of the judgement sought to be reviewed:

April 27th, 1992.

(ii) The date of the order respecting a rehearing:

September 3rd, 1992.

The date and terms of the order granting an extention of time within which to file the petition for a writ of certiorari:

Entered December 15th,

1992.

Granted to January 21st, 1993.

(iv) The statutory provision believed to confer on this Court jurisdiction to review the judgement or decree in question by writ of certiorari:

This Petition is based upon Supreme Court Rules 10(.1)(a) and (c).

Supreme Court Rule 14(.1)(f)

CONSTITUTIONAL PROVISIONS AND STATUTES

The Fourteenth Amendment to the U.S. Constitution.

Florida Statute 627.607.

Florida Statute 627.409.

Please see Appendix for verbiage of the above inasmuch as they are too lengthy to present here.

Supreme Court Rule 14(.1)(g)

Please see the narritive - herewith - pages 1-19.

Supreme Court Rule 14(.1)(i)

In re statement of the case the basis invoked by Plaintiff for Federal Jurisdiction is Diversity.

Supreme Court Rule 14(.1)(j)

Please see the narritive - herewith - pages 20-45.

CONCISE STATEMENT OF THE CASE

On February 4th, 1986, the Petitioner, Thomas B. Kee applied for a disability insurance policy with the Respondent Provident Life Insurance Company. The application was approved and bore an issue date of April 25, 1986 and an effective date of May 5, 1986.

In filing its action to rescind Kee's policy, Provident contended that Kee had made certain material misrepresentations in completing his application. Although asserting that Provident's rescission claim was barred by the two-year contestability limitation contained in the policy, Kee never conceded that he had made

any material misrepresentations in the application, contrary to the allegations made by Provident (Exhibit "A" - Trial Court Pleadings and Provident's Answer Brief).

In fact, this is only one of the several remarkable examples of the way Provident has cleverly cited the record on appeal in order to create "facts" which never existed. Kee has consistently denied having ever made any material misrepresentations in his application and stands by that assertion to this day.

Kee truthfully answered all the questions to the best of his knowledge since the pertinent questions asked if he had ever been <u>treated</u> for any of the illnesses. At the time that Kee was seeing his psychiatrist, Dr.

Arthur Stillman, he was not advised by the doctor or anyone else that he was suffering from bi-polar affective disorder or any other illness, mental or otherwise (Exhibit "B").

Therefore, Kee continues to stand by his original statement that he was answering these questions truthfully and still contends that he was not suffering from any illness that had manifested itself at that time. In Kee's case, even though the illness had been diagnosed by Dr. Stillman, it had not manifested itself in any way whatsoever nor had it affected Kee's behavior or obvious ability to earn a living.

It should be noted that in completing the application, Kee received the assistance of Provident's general

agent at the time, Michael Eskra. Not only did Eskra make suggestions but he also completed portions of the application in order to expedite the issuance of the policy.

On May 4, 1986, one day prior to the expiration of the incontestability period (using the effective date as controlling), Provident filed an action in the Southern District of Florida to rescind the policy. The date of the Provident action cannot go unnoticed since Kee had not filed a claim under the policy and had not even suggested that he would at the time the action for rescission took place.

When viewed in the context of the Florida statute involved, it becomes apparent that Provident may

have outwitted itself in its attempt to file its action at the last possible moment. It will be shown that the statute in question as well as many others affecting the insurance industry were drafted by the legislature while under considerable pressure from the insurance industry.

A detailed examination of the history of the incontestability provisions as they apply to insurance contracts reveals that they were designed to cure the evils which had become rampant throughout the insurance industry. Before the enactment of legislation in the form of mandatory incontestability clauses in insurance policies, it had become standard practice within the insurance industry to underwrite policies at the time

a claim was filed.

In other words, insurance companies were waiting until claims were filed in order to begin their search for possible misrepresentations in the original application. This procedure left the policy holder virtually helpless since he was at the mercy of unscrupulous insurance companies which could deny coverage for practically any reason after having collected premiums for many years.

This intolerable process was compounded even further in Petitioner's case in that this type of unethical conduct was initiated before Kee filed a claim or even suggested that one would be filed. After all, anyone intent on deceiving an insurance company by misrepresenting

his medical history would never alert them in advance by filing a claim prior to the expiration of the incontestability period but rather would "wait out" the appropriate period in the hope that his designs were not uncovered (Exhibit "C").

Assuming arguendo that Provident was within its rights in launching its last-minute and perfuntory investigation, it still fits the pattern of abuse which characterized the behavior of the insurance industry back in the days in which it was allowed to operate virtually unrestrained by any governmental controls.

Despite repeated attempts by the various legislatures to correct this problem, the abuses still continue and, in some cases, have become even

more obvious. A litany of reasons can be cited for the continuing nature of these problems but primary among them is the lack of uniformity from state to state and the hopelessly vague and confusing interchangeability in the use of contradictory terminology in the drafting of state statutes which ostensibly were designed to cure the problem.

The Florida Statute on the incontestability of an insurance policy is a case in point. Florida Statute section 627.607 (1982) reads as follows:

> The contract shall include the following provision:
>
> (1) Time Limit on certain defenses: After 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss

incurred or disability starting after the 2-year period.

(2) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least 5 years from its date of issue may, in lieu of the provision set forth in subsection (1) include the following provision:

Incontestable:

(a) Misstatements in the Application: After this policy has been in force for 2 years during the insured's lifetime (excluding any period during which the insured is disabled), the insurer cannot contest the statements in the application.

(b) Preexisting Conditions: No claim for loss incurred or disability starting after 2 years from the issue date will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before

> the effective date of coverage. (emphasis added).

Even a cursory examination of the statute reveals the confusion which could easily result from the continuous use and interplay among the various terms used to determine the triggering dates for measuring the contestability period.

When one considers the fact that even the courts have agonized over the meaning of these terms and their applicability to insurance contracts, it becomes readily apparent that the average policy holder could not be expected to decifer the subtle differences which accompany the use of these phrases and the effect they could have upon their rights under the policy.

The statute gives the insurer the option of substituting for one or more of the provisions, corresponding provisions of different wording approved by the Department of Insurance which are, in each instance, not less favorable in any respect to the insured. (30 Fla. Jur. 2d Sec. 371).

Provident has chosen to reword the incontestability clause of its policy which endeavors to make the policy, as a whole, less favorable to the insured by substituting the words "effective date" in place of "issue date".

The Florida courts apparently have never made a determination of the precise meaning of the term "in force" as it applies to a policy of disability insurance. However, other

jurisdictions have had been called upon to clarify statutes which contain similar language and have reached varying conclusions.

In GUARDIAN LIFE INSURANCE COMPANY OF AMERICA, INC. v. SCHAEFER, 519 N.E. 2d 288 (NY 1987), 524 N.Y.S. 2d 377 (Ct App. 1987), the New York Court of Appeals held that the two-year incontestability period began to run from the date of the disability policy's issuance, rather than the the policy's effective date, in that the term "in force", as used in the incontestability clause was ambiguous and would be construed against the drafter of the policy.

The Court in SCHAEFER stated: "Resolution of this dispute depends on whether the term "in force", as

used in the incontestability clause, means the "date of issue" or the "effective date" of the policy. Nowhere does the policy itself or the applicable statute governing incontestability clauses in accident and health policies define the term "in force". That phrase arguably could apply to either the date of issue or the effective date. Thus, the term "in force" is ambiguous and the rule of construction that ambiguities in contracts must be construed against the drafter is applicable". SCHAEFER at p. 378.

The New York Statute, upon which the Court's decision was based, contains language almost identical to the Florida Statute as it relates to the substitution of provisions utilizing different wording than what

is mandated by the statute itself and requiring that the substituted provision not be less favorable in any respect to the insured.

The determination of the date when the policy becomes effective has been a troublesome one to the courts for many years. The courts have been faced with the problem on the one hand of enforcing a contract as made, and on the other of giving a liberal construction to such contracts, recognizing that such contracts are drafted wholly by one party thereto, and that the other is inexperienced in such matters and usually unaware of the legal effect of such instrument.

Because of these various matters of public policy confronting the courts, there are no uniform rules

laid down which absolutely govern the time when the contract is considered to go into effect. However, the courts have made an effort to adopt dates as controlling that would allow them to find that the contestable period had run.

Of critical importance in analyzing the applicability of the incontestability clause to Kee's policy is the fact that the policy at issue in the instant case was, in effect, a continuation of several non-cancellable policies which Kee had owned for some 23 years prior to their unexplained lapse and cancellation by Provident in 1985. Provident's own general agent exercised a great deal of influence over Kee in convincing him to purchase a new policy instead

of reinstating the old ones.

It should be noted that the Petitioner tendered a payment of $400 and signed for the Provident general agent an INSURmatic bank draft form (which Provident takes in lieu of a binding check) at the time of the application for the purpose of binding the new policy since he was about to embark on an around-the-world trip shortly thereafter. He was assured by Provident's general agent that the payment would be sufficient at the time and he would be advised when the next payment would be due.

Additionally, Kee could easily have bound the policy himself and retained the estimated premium since he could act as the agent for his own policy and thereby forego the necessity

of collecting any money at all. (Exhibit "D"). The agent would be due his commissions for generating the business thereby reducing the amount of premium payment needed to bind the policy. In this context, Kee's tendering of $400 was more than sufficient to meet this requirement.

Kee had a right to feel that he was covered under the terms of the policy since the average applicant who has paid his premium and successfully passed his physical examination would not by the remotest chance understand that he was not covered until the insurer at his leisure approved the risk; he would assume that he was getting immediate coverage for his money.

The need for a higher premium

would never have become an issue had Provident's own general agent, Eskra, not sought higher coverage. In fact, it was at Eskra's suggestion that Kee opted for increased coverage while assuming at the time that the previously-quoted premium was applicable to the higher coverage. (Kee had no access to nor understanding of Eskra-Provident's premium computers in their offices which were seperate from his own and therefore had to rely on Provident's employees for advice.) Additionally, Kee had long before opted to have his premium payments deducted from his commission check while working for another insurance company through what is known as the Employee Deduction/INSUREmatic account.

Nevertheless, had Provident

determined that the check tendered by Kee with his application was an inadequate amount to cover the policy, they should have informed him within 10 days so that any shortage could be resolved.

PROCEEDINGS IN LOWER COURT

On May 4, 1988, Provident filed an action to rescind Kee's disability insurance policy on the basis that Kee's application contained material misrepresentations. While focusing on the 2-year contestability period as a bar to Provident's action to rescind the policy, Kee made no concessions regarding the issue of material misrepresentations, contrary to Provident's assertions (Exhibit "A", supra).

On June 15, 1990, the district court entered summary judgment in favor of Provident (Exhibit "E"). In so ruling, the district court found that Provident had filed its action for

rescission prior to the expiration of the policy's 2-year contestability period.

Summary judgment was granted by the district court despite the fact that there were several genuine issues of material fact which remained to be resolved. These included, but were not limited to, the materiality of the alleged misrepresentations, Kee's state of mind at the time the application was completed and the amount of premium necessary to bind the policy.

On August 23, 1990, Kee filed his Notice of Appeal with the Eleventh Circuit Court of Appeals. On April 27, 1992, the Eleventh Circuit Court of Appeals affirmed the judgment of the district court stating that the action was filed within the two-year

period allowed to contest statements made in the application. Additionally, the Court held that there was no dispute concerning misrepresentations in the relevant medical history and that the policy would not have issued but for those omissions.

As the result of these adverse rulings and certain constitutional issues raised thereby, Kee has filed the instant Petition for Writ of Certiorari with this Court.

ARGUMENT

Provident's action to rescind Kee's policy of non-cancellable and guaranteed renewable disability insurance was predicated on the allegation that certain misrepresentations had been made in the application for insurance and that these alleged misrepresentations allowed for rescission by Provident under Florida Statute 627.409(1)(1987). Provident successfully argued in the lower court that the applicant's state of mind made no difference and that even an innocent misrepresentation was grounds for rescission of the policy if it were material to the acceptance of the risk.

In completing the application, Kee was asked if,"within the past five years he had had any mental or physical disorder", to which the applicant responded "no". (Question 5a of Provident's application). This answer was given truthfully to the best of Kee's knowledge since he was totally unaware of any diagnosis pertaining to the bi-polar affective disorder of which he later learned he had been suffering. The psychiatrist who examined Kee, Dr. Arthur Stillman, had never revealed to him the results of his diagnosis but instead had shared the information with Kee's attorney and no one else (Exhibit "B", supra).

The main focus of Provident's argument was the statutory language of the afore-mentioned Florida Statute

627.409(1) which reads in pertinent part that:

> "Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless:
>
> a. They are fraudulent.
>
> b. They are material, either to the acceptance of the risk or the hazzard assumed by the insurer: or
>
> c. The insurer in good faith would either not have issued the policy or contract, would not have issued it at the same premium rate, would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazzard resulting in the loss if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

Kee has argued vehemently

that he had no way of knowing that he was suffering from any potentially debilitating illness at the time he filled out the application. However, Provident relied heavily upon the holding in LIFE INSURANCE COMPANY OF VIRGINIA v. SHIFFLET, Fla. 1967, 201 So2d 715, which states that even an innocent misrepresentation by the insured can bar recovery if it is material to the acceptance of the risk or if the insurer, in good faith, would not have issued the policy under the same terms had it known the truth.

In HYMAN v. LIFE INSURANCE COMPANY OF NORTH AMERICA, 481 F2d 441 (1973) the Court recognized that the SHIFFLET holding did have its exceptions and, in certain instances, could produce harsh results. In a concurring opinion,

joined by three other Justices, in NATIONAL STANDARD LIFE INSURANCE COMPANY v. PERMENTER, 204 So2d 206 (Fla. 1967), Justice Ervin suggested a case-by-case approach to avoid injustice in situations in which

> "an applicant may express an erroneous opinion concerning a specific question relating to his health, of which he has no medical knowledge, and which could only be answered by a medical expert after diagnosis and examination."

204 So2d at 207.

Provident recognizes the fact that the SHIFFLET rationale suffered a gradual erosion by subsequent appellate court decisions but was reaffirmed and revitalized by the Florida Supreme Court in CONTINENTAL

ASSURANCE CO. v. CARROL, 485 S0 2d 406 (Fla. 1986). However, in an intermediate decision by the Fourth District Court of Appeals, CONTINENTAL ASSURANCE CO. v. CARROLL, 459 So2d 443 (Fla. App. 4 Dist. 1984), the court had certified the question raised in the SHIFFLET case, i.e. the impact of a material misrepresentation to the acceptance of the risk and whether it would invalidate an insurance policy even if made in good faith, as being one of great public interest.

The constant ebb and flow that has been the trademark of the SHIFFLET rationale over the years was further manifested in the recent case of WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK v. SANDS, 912 F.2d 1359, in which the Eleventh Circuit Court

of Appeals further eroded the holding in CARROLL, and by extension, SHIFFLET, when it held that when the insurance company requests that the applicant answer the questions on the application to the best of his knowledge and belief, it was not entitled to rescission of the policy when negative responses were later proved to have been incorrect when they were made.

As the Court in SANDS stated:

> "An essential prerequisite to the application of Florida Statutes section 627.409(1) is that the insured make an inaccurate statement in his application."

If the insured had no knowledge of his illness at the time of the application, it would be impossible for him to make an incorrect

statement.

The Court in SANDS, quoting from SKINNER v. AETNA LIFE AND CASUALTY in which the interplay between an insurance statute and contract was considered, stated with regard to the inclusion of the qualifying language

> "to the best of my knowledge and belief,"

that the additional verbiage

> "..... had the effect of shifting the focus, in a determination of the truth or falsity of an applicant's statement, from an inquiry into whether the facts asserted were true to whether, on the basis of what he knew, the applicant believed them to be true. Thus (the applicant's) answer must be assessed in the light of his actual knowledge and belief."

The application for the Provident policy clearly contains the qualifying language referred to above (Exhibit "F") and, as such, falls within the SANDS holding whereby the applicant's knowledge of the facts forming the basis for his responses is controlling.

The Eleventh Circuit has arrived at the same conclusion in evaluating the effect of insurance contract language that provides an applicant with greater protection than the relevant state insurance statute. The Court, qouting from STATE FARM FIRE AND CASUALTY CO. v. OLIVER, 854 F. 2d 416 (11th Cir. 1988), dealing with an Alabama statute in all material respects identical to Florida Statute section 627.409, stated that

> "once (the insurer) has set its own standard by contract for judging misrepresentations and concealment, it cannot rely on a statute that imposes more stringent requirements on an insured."

To allow Provident to resort to the safe harbor of the statutory language provided by section 627.409(1) when it chose to include qualifying language of its own in the policy application, would provide Provident with the opportunity to contest any statement made in an application as a pretext for later rescinding the policy.

The continuing erosion of the SHIFFLET holding and the decided advantage which insurance companies enjoy over the average policy holder require that the goal of uniformity

in this area of the law be achieved once and for all. In order to ensure that the policy holder is not unfairly victimized by insurance companies which, in effect, are allowed to underwrite at the time of claim instead of application, it must be established that the insurer is bound by the terms of the contract it enters with the insured, especially in those cases where the insurer has carefully chosen the very terms and conditions which have later become a source of conflict.

As additional support for Kee's contention that he was unaware of the illness which later became the subject of dispute, reference is made to the testimony at Hearing of the late Dr. Arthur Stillman on where he was asked on January 9th, 1989 (Exhibit

"B", supra):

A. No. I didn't actively treat him. (p 21)

Q. . . . did you ever go into a full explanation of what your understanding, your evaluations were with Mr. Kee? (p 21-22)

A. No.

Q. Did you, in fact, prepare any evaluations that were sent to the attorney for Mr. Kee?

A. Yes.

Q. And did those evaluations go into your findings relating to Mr. Kee's mental health?

A. I think they went into it in fairly notable detail, yes.

Q. . . . were those reports or written evaluations that you prepared ever given to Mr. Kee? (p 22-3)

A. No. I never gave him--no.

Q. And you never

explained those evaluations to Mr. Kee?

A. No. I felt that was up to his attorney. (Emphasis added.)

pp. 21-23 of Stillman Court transcript.

There was no reason for Kee to believe that Dr. Stillman's prescriptions for lithium and tranquilizers were related to a bi-polar affective disorder. After all, Dr. Stillman himself admitted that he never officially treated Kee but merely examined him at the behest of his attorney. Kee was advised that the medication would help him sleep better and control his nerves.

This background is important in that the questions relevant to this case were preceded in the application by the phrase

"have you ever been treated"

for any of the following disorders. Given Dr. Stillman's own assessment of his examination of Kee, it can readily be seen that Kee correctly responded to the series of questions preceded by the phrase mentioned above.

It should be noted that Kee's condition was in the incipient stage at the time of his application for disability insurance and none of the symptoms had manifested themselves to such an extent that the average man would have been fully aware of them.

At the end of Provident's application appears the very qualifying language at issue in the SANDS case, i.e.

> "the foregoing statements are full, complete, and true to the best of my knowledge and belief."

Directly below this statement is the signature of the appellant, Thomas B. Kee.

In order to properly construe the applicant's responses to the questions posed, they must be read, as the insurance form itself states, in conjunction with the qualifier

> "to the best of my knowledge and belief."

Taken in that context, Kee's negative response to question 5a

> "Have you within the past 5 years had any mental or physical disorder not listed above",

was neither a misstatement nor a misrepresentation; they were entirely truthful and accurate.

By including the phrase

> "to the best of my knowledge and belief",

the parties have chosen a subjective test for the truthfulness of prior representations. What the applicant in fact believed to be true is the determining factor in judging the truth or falsity of his answer.

The court in SANDS, supra, held that the

> "knowledge and belief"

language used in an application form imposes a different requirement of accuracy than that provided in section

627.409 Florida Statutes. Had Provident intended to retain the ability to void the contract based on any inaccuracy, it should not have used the

"knowledge and belief"

qualifying language. Such language would reasonably induce an insurance applicant to believe that they were covered under the policy if they answered the questions to the best of their knowledge and the insurer subsequently issued the policy. To permit an insurer to rescind a policy containing

"knowledge and belief"

language due to an unknowing misstatement not only contravenes the

terms of the contract itself, but is unfair as well. Insurance applicants faced with a policy that unambiguously stated that it could be voided for unknowing misstatements might have rejected those terms and sought another policy, or they might have undergone a full physical examination to ensure that their beliefs as to their health conformed to their representations. Conversely, had Provident really thought it essential to know the actual physical condition of its applicants, it could have mandated a full physical examination and investigation as a condition of issuing a policy.

The courts have established safeguards in order to ensure that the applicant cannot claim ignorance of otherwise obvious medical conditions.

In SKINNER, supra, the court held that what the applicant in fact believed to be true is the determining factor in judging the truth or falsity of his answer, but only so far as that belief is not clearly contradicted by factual knowledge on which it was based. In such event, the court may properly find the statement false as a matter of law, however sincerely it may be believed.

CONCLUSION

It is respectfully submitted that the Petitioner in this case belongs to a class of people whose plight has become all too familiar over the years. The clout which is wielded by the insurance industry in the halls of the various state legislatures has risen to legendary status.

Petitioner has demonstrated in his brief that the statutory provisions regulating the insurance industry, instead of clarifying the issues, have muddied the waters and left the issues to be resolved by the court system. However, instead of achieving uniformity in the areas of material misrepresentation and

incontestability provisions, the decisions of the courts have led to even greater confusion.

It is difficult to imagine a topic of more importance to the average American than access to affordable and reliable insurance for one's family. If insurance companies such as Provident are allowed to continue to enjoy the upper hand in determining the terms, and in some cases the very existence, of an insurance contract, the american public will find itself at the mercy of an ever-growing enterprise which can leave it virtually helpless at the time of greatest need.

The need for uniformity in an industry whose very existence depends upon its credibility among the policy

holders and the unfair advantage it enjoys over the average insured is so obvious that it need not be stated.

Provident has placed itself in the most unenviable position of being one of the most litigious companies in the insurance business, having involved itself in litigation far out of proportion to its size. This fact lends further credibility to the assertions previously made.

It is well documented that Provident has used its leverage within the industry to invade the domain of the federal government where its high-handed tactics have resulted in accusations of Medicare fraud whereby millions of dollars of taxpayer money has been squandered. It can safely be said that such abuses will continue

if left unchecked. (Please see Exhibit "G" - front page Sunday article in the MIAMI HERALD daily newspaper.)

The Petitioner prays that this Honorable Court will seize this opportunity to tighten the reigns on an industry which has grown to unwieldy proportions and to achieve the uniformity of judicial decision-making which is so desperately needed.

Supreme Court, U.S.
FILED

931509 JAN 21 1993

OFFICE OF THE CLERK

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OCTOBER TERM 1993

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

APPENDIX

THOMAS B. KEE, PRO SE

8475 SW 155th Terrace
Miami, Florida 33157
(305) 255 1000
Fax (305) 235 4532

62 pp

CONSTITUTIONAL PROVISIONS RELIED UPON

Section 1, 14th Amendent to the United States Constitution:

All persons born or naturalized in the United States, subject to the jurisdiction thereof, are citizens of the United States and the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or amenities of the citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection

of the law.

FLORIDA STATUTES

627.607. Time limit on certain defenses

(1) The contract shall include the following provision:

"Time limit on Certain Defenses: After 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the 2-year period."

(2) A policy which the insured has the right to continue in force subject to the terms by the timely payment of premium until at least age

50 or, in the case of a policy issued after age 44, for at least 5 years from its date of issue may in lieu of the provision set forth in subsection (1) include the following provision:

"Incontestable:

(a) Misstatements in the Application: After this policy has been in force for 2 years during the insured's lifetime (excluding any period during which the insured is disabled), the insurer cannot contest the statements in the application.

(b) Preexisting Conditions: No claim for loss incurred or disability starting after 2 years from the issue date will be reduced or denied because

a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage."

FLORIDA STATUTES

627,409(1). Representations in applications; warranties

(1) All statements and descriptions in any application for an insurance policy or annuity contract, or in negotiations therefor, by or in behalf of the insured or annuitant, shall be deemed to be representations and warranties. Misrepresentation, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless:

(a) They are fraudulent;

(b) They are material either to the acceptance of the risk

or to the hazard assumed by the insurer; or

(c) The insurer in good faith would either not have issued the policy or contract, would not have issued it at the same premium rate,would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

(DO NOT PUBLISH)

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

Nos. 90-5711, 91-5435
Non-Argument Calendar

D.C. Docket No. 88-793-Civ-KLR

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY,

Plaintiff-Appellee

versus

THOMAS B. KEE,

Defendant, Appellant.

Appeals from the United States District Court
for the Southern District of Florida

(April 27th, 1992)

Before FAY, HATCHETT and DUBINA, Circuit Judges

PER CURIAM:

The judgement of the district court is affirmed for the reasons stated in the Summary Final Judgement dated June 15, 1990.

Based upon the uncontradicted facts, the effective date of the policy in question was May 5th, 1986. Consequently this action was filed within the two year period allowed to contest statements made in the application. Since there is no dispute concerning misrepresentations in the relevant medical history and that the policy would not have issued but for those omissions, appellee was entltled to prevail.

AFFIRMED.

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

Nos. 90-5711, 91-5435

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY,

Plaintiff-Appellee

versus

THOMAS B. KEE,

Defendant, Appellant.

On Appeal from the United States District Court for the Southern District of Florida

---

Before FAY, HATCHETT and DUBINA, Circuit Judges

BY THE COURT:

Appellee's motion to strike portions of Appellant's reply brief in case No. 90-5711 is denied.

Appellant's motion to quash

Appellee's motion to strike portions of the reply brief in case No. 90-5711 is denied.

Appellee's motion for attorney's fees in case No. 91-5435 is denied.

Appellant's motion to quash Appellee's motion for attorney's fees in case No. 91-5435 is denied.

PLEASE SEE

EXHIBIT "E"

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

Nos. 90-5711, 91-5435

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY,

Plaintiff-Appellee

versus

THOMAS B. KEE,

Defendant, Appellant.

On Appeal from the United States District Court for the Southern District of Florida

---

ON PETITION(S) FOR REHEARING AND SUGGESTION(S) OF REHEARING EN BANC

(Opinion April 27, 1992, 11th Cir., 1992, _____F.2d____)

Before: FAY, HATCHETT and DUBINA, Circuit Judges.

PER CURIAM:

(X) The Petition(s) for Rehearing are DENIED and no member of this panel nor any other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

(S) PETER FAY
UNITED STATES CIRCUIT JUDGE

EXHIBIT "A"

IN THE UNITED STATES
DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF
FLORIDA

CASE NUMBER:88-793-CIV-RYSKAMP

PROVIDENT LIFE AND
ACCIDENT INSURANCE COMPANY,

Plaintiff,

vs.

THOMAS B. KEE,

Defendant.
_____/

MOTION FOR SUMMARY JUDGEMENT AND
MEMORANDUM OF LAW IN SUPPORT
THEREOF

Page 2

INTRODUCTION

In this action, Provident seeks to rescind the disability insurance policy issued to defendant on the ground that dafendant made material misrepresentations regarding his medical

history in his application for said policy.

Respectfully submitted,
SHUTTS & BOWEN
Attorneys for Plaintiff
1500 Edward Ball Building
100 Chopin Plaza - Miami Center
Miami, Florida 33131
(305) 358 6300

_____
John E. Meagher

I HEREBY CERTIFY that a true and correct copy of the foregoing has been mailed this 22nd day of June, 1989 to (counsel for Defendant).

IN THE UNITED STATES
DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF
FLORIDA

CASE NUMBER:88-793-CIV-RYSKAMP

PROVIDENT LIFE AND
ACCIDENT INSURANCE COMPANY,

Plaintiff,

vs.

THOMAS B. KEE,

Defendant.
_____/

(DEFENDANT'S) RESPONSE TO
MOTION FOR SUMMARY JUDGEMENT

Page 2

10. Thomas B. Kee made no fraudulent misrepresentations in his application for this policy.

CARUSELLO & HUNNEFELD, P.A.
Attorney for Defendant

_____
Henry J. Hunnefeld, Esquire

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served/mailed/faxed this 5th day of July, 1989 to (counsel for Plaintiff).

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

NO. 90-5711

THOMAS B. KEE,

Appellant,

v.

PROVIDENT LIFE AND ACCIDENT
INSURANCE COMPANY,

Appellee.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF FLORIDA

BRIEF OF THE APPELLEE

Brenton N. Ver Ploeg, P.A
John E. Meagher
Michael B. Berger
SHUTTS & BOWEN
Attorneys for Appellee
201 South Biscayne Boulevard
1500 Miami Center
Miami, Florida 33131
(305) 358-6300

STATEMENT OF THE CASE

Page 3

While conceding that he had, in fact, made material misrepresentations in his application, Kee asserted that, Provident's rescission claim was barred by the 2-year contestability period contained in the policy.

(Kee's Note - these are the pertinent passages of the three Pleadings of Exhibit "A". They are excerpted from the original Petition Exhibits which are available in a Lodging with the Clerk.)

EXHIBIT "B"

IN THE CIRCUIT COURT OF
THE ELEVENTH JUDICIAL
CIRCUIT IN AND FOR DADE
COUNTY, FLORIDA

CRIMINAL DIVISION
(Carney)

CASE NO. 85-28482

THE STATE OF FLORIDA,

Plaintiff,

vs.

THOMAS B. KEE,

Defendant.
_____/

Miami, Florida

January 9, 1989

The above-entitled cause came on for hearing before the Honorable Thomas M. Carney, judge of the above-styled court, at the Metropolitan Justice Building, 1351 Northwest 12th Street, Miami, Florida, on January 9, 1989, at or about 1:30 p.m.

To Arthur Stillman, M.D.:

Q. Okay. Now, did you, in fact, evaluate Mr. Kee?

A. Yes. I did so on December 3, 1984.

Q. Was that the first time you had a face-to-face meeting with Mr. Kee?

A. Yes.

Q. Did you subsequently have the opportunity to meet with Mr. Kee?

A. Yes. I evaluated him some four times after that.

Q. Okay. Now, at any time, did you actually treat Mr. Kee?

A. No. I didn't actively treat him.

Q. During that time frame, specifically meaning 1984, '85, or

'86, during that time frame.

A. I didn't really treat him. I advised him about treatment, but I didn't actively treat him.

Q. And--but, did you ever go into a full explanation of what your understanding, your evaluations were with Mr. Kee?

A. No.

Q. Okay. Except for the most recent ones, 1988--during 1984, '85, and '86, were those reports or written evaluations that you prepared ever given to Mr. Kee?

A. No. I never gave him--no.

Q. And you never explained those evaluations to Mr. Kee?

A. No. I felt that was up to his attorney.

Q So you were actually hired

and paid by Mr. Kee's attorney at that time for the specific purpose which you complied with.

A. I believe so.

EXHIBIT "C"

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

NO. 90-5711

THOMAS B. KEE,

Appellant,

v.

PROVIDENT LIFE AND ACCIDENT
INSURANCE COMPANY,

Appellee.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF FLORIDA

BRIEF OF THE APPELLEE

Brenton N. Ver Ploeg, P.A
John E. Meagher
Michael B. Berger
SHUTTS & BOWEN
Attorneys for Appellee
201 South Biscayne Boulevard
1500 Miami Center
Miami, Florida 33131
(305) 358-6300

Page 5

On or about December 2, 1987, Kee notified Provident that he intended to file a disability claim. (R1-26-3). (Kee's comment - PROVIDENT HAS NO CLAIM OR NOTIFICATION.) Kee, however, did not file a claim form with Provident until shortly after September 1, 1988. (R1-26-3) In his claim form, Kee stated he was totally disabled due to a "bipolar affective disorder" which began on an undetermined date. (R1-26-3,4) Provident's subsequent claim investigation (Kee's comment - INAPPROPRIATE.) revealed that Kee's medical history was not fully disclosed in the application. (R1-26-4).

(Kee's note - A Lodging of the original pleadings have been filed with the Clerk.]

IN THE UNITED STATES
DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF FLORIDA

CASE NUMBER:88-793-CIV-RYSKAMP

PROVIDENT LIFE AND
ACCIDENT INSURANCE COMPANY,

Plaintiff,

vs.

THOMAS B. KEE,

Defendant.
_____/

Page 3 - Appellee's pleading

LOCAL RULE 10(J)(2) STATEMENT OF
MATERIAL FACTS AS TO WHICH THERE IS
NO GENUINE ISSUE TO BE TRIED

Page 3

On or about December 2, 1987, defendant notified Provident that he intended to file a disability claim.

(Kee's comment - PROVIDENT HAS NO CLAIM OR NOTIFICATION.)

and

Page 4

Provident's subsequent claim investigation revealed that Kee's medical history was not fully disclosed in the application. (R1-26-4). (Kee's comment - INAPPROPRIATE.)

(Kee's note - These are the pertinent passages of the three Pleadings of Exhibit "C" which are available in a Lodging with the Clerk).

PLEASE SEE

EXHIBIT "E"

EXHIBIT "D"

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY

CHATTANOOGA, TENNESSEE

AGENTS AGREEMENT

ACCIDENT DEPARTMENT

The Accident Department of Provident Life and Accident Insurance Company, called the Company in this agreement, and Thomas B. Kee of Miami, Florida, called the Agent, agree as follows:

1) The Company appoints the Agent, directly or through its General Agent, to solicit and submit applications for individual health insurance policies within the prescribed territory, to deliver policies issued

from those applications and to receive initial premiums, transmitting them to the Company.

2) The Agent will be entitled to commissions on premiums received by the Company for policies issued from applications secured by the Agent according to the schedule below.

Divisions 6 and 76	50%
Division 66	30%

The Company may vary commission rates for policy forms which may be introduced after this agreement is effective. [Emphasis added.]

(Kee's note - This Agent's agreement

was dated April 7, 1978 and is available in its entirety, with other exhibits, in the Lodging filed with the Clerk.)

EXHIBIT "E"

IN THE UNITED STATES
DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF FLORIDA

CASE NUMBER:88-793-CIV-RYSKAMP

PROVIDENT LIFE AND
ACCIDENT INSURANCE COMPANY,

Plaintiff,

vs.

THOMAS B. KEE,

Defendant.
_____/

SUMMARY FINAL JUDGEMENT

The Plaintiff, Provident Life and Accident Insurance Company (Provident), brings this action seeking rescission of a disability insurance policy issued to defendant, Thomas B. Kee (Kee). Kee filed a claim under the policy and Provident denied the claim on the basis that Kee had made material misrepresentations regarding

the medical history in his application for insurance. Provident maintains that it is entitled to rescission pursuant to Florida Statutes (1982) section 627.409(1)(b) and (c) because the misrepresentations were material to the acceptance of the risk. Provident has moved for summary judgement contending that there is no genuine issue of material fact and that it is entitled to judgement as a matter of law pursuant to Rule 56. See Celotex Corp. v. Catrett, 477 U.S. 317, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986).

In opposing the motion for summary judgement, Kee does not deny that material misrepresentations were made in the application for insurance. Instead, Kee contends that Provident

is not entitled to summary judgement because the incontestability clause in the policy bars Provident from contesting the misrepresentations after the policy has been "in force" for two years. Additionally, Kee moved for summary judgement on the ground that no genuine issue of material fact exists as to the incontestability of the misstatements and that he is entitled to a judgement as a matter of law.

In accordance with Florida law/1, the policy of insurance

1/ Florida Statutes (1982) section 627.607 provides:

(1) The contract shall include the following provision:

"Time limit on Certain Defenses: After 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability starting after the 2-year period."

(2) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least 5 years from its date of issue may, in lieu of the provision set forth in subsection (1) include the following provision:

"Incontestable:

(a) Misstatements in the Application: After this policy has been in force for 2 years during the insured's lifetime (excluding any period during which the insured is disabled), the insurer cannot contest the statements in the application.

(b) Preexisting conditions: No claim for loss incurred or disability starting after 2 years from the issue date will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage." (emphasis added).

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issued by Provident contained the following provision:

INCONTESTABLE

1. After this policy has been in force for two years during your lifetime, we cannot contest the statements in the application.

2. No claim for loss incurred or disability that starts after two years from the Effective Date of this policy will be reduced or denied on the ground that a sickness or physical condition not excluded by name or specific description had existed before the Effective Date of this policy by paying premiums when due. (emphasis added).

with the terms of the statute and the policy clearly defined, the sole issue for this court on the motions for summary judgement is whether Provident brought this action within two years after the policy was "in force".

Although the phrase "in force'

has not been defined by either the Florida Legislature or the policy issued by Provident, Florida courts have equated the phrase "in force" with the phrases "in effect" and "effective date." See Prudential Insurance Company of America v. Rhodriquez, 285 So.2d 689, 690 (Fla. 3d DCA 1973) ("From a reading of the incontestability clauses, it is clear that after the policies are in effect for two years they would become incontestable."); and Aetna Life Insurance Company v. Thorn, 315 So.2d 219, 220 (Fla. 3rd DCA 1975) ("After reading the [incontestability] clause which is unambiguous, it is abundantly clear that as of June 7th, 1971, the effective date of the policies, the two year period thereunder began to run, and,

therefore, appellant's action for rescission filed on June 7th, 1973 was untimely.")

Furthermore, the following language of the policy indicates that the policy would be "in force" when it bacame "effective":

Effective date of insurance

The effective date is based on several considerations i.e., date of application and medical examination, payment of premium, and physical insurability.

If (1) at least 1/6 of the annual premium for the policy applied for is paid with the application; and (2) the medical examination and supplementary tests, if required, are completed within 90 days of the date of the application; and (3) the proposed insured is insurable under our underwriting rules and practices for the policy and amount applied for, with no restriction and no change in coverage at our standard rate of premium; the individual policy will be dated and the insurance will be in force on the later of:

a) the date of the application;

b) the date of completion of Provident's medical examination and supplementary tests, if required; or

c) the date requested by the proposed insured at the time of the application, but not more than 90 days after the date of the application.

Where coverage is issued as above, the individual policy will not be redated since coverage has been in effect since the effective date.

Premium payment at time of application is not required for Employer sponsored salary allotment applications. All other requirements are applicable.

When any of the above conditions is not met and an individual policy is issued, it will have an effective date 10 days after the issue date. The policy may be delivered and will be in force upon payment of the full first term premium so long as the proposed insured's state of health is the same as that stated in the application. (emphasis added).

According to the terms of the policy, if Kee satisfied the three conditions precedent, then the policy was "in force" on February 4th, 1986, the application date, and this case

is barred by the incontestability clause of the policy because Provident did not bring this action until May 4th, 1988, more than two years later. However, if any of the conditions were not met, the policy was "in force" on its "effective date," May 5th, 1986, and this case would not be time-barred because Provident brought suit within two years of the effective date of the policy.

Although Kee maintains that he satisfied the three conditions precedent to having the policy "in force" on the application date, this argument is belied by the facts of this case. Contrary to his contention, Kee did not satisfy the first condition precedent bwecause he did not pay 1/6 of the annual premium at the time of

application./2 Moreover, Kee did not satisfy the third condition precedent because a change in coverage under the policy occurred. Kee's attempt to undermine the significence of this fact by pointing out that the change was brought about at his request, as opposed to Provident's, is unavailing. Nothing in the language of the policy indicates that satisfaction of this condition depends upon whether the change was instigated by the

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2/Kee maintains that he paid 1/6 of the premium because at the time of application his premium was only $682.90 and he tendered an amount of $400.00. However, before that policy was issued, Kee requested that his coverage be increased from $1,000 to $3,800. Because of this increase in coverage, the amount of the annual premium was increased to $3,020.86. Thus, to satisfy the condition precedent of paying 1/6 of the annual premium for the policy that was ultimately

issued, Kee was required to tender approximately $503.00. Although he paid the annual premium in full in July of 1986, at the time of application he tendered only $400.00. Thus, it is clear that at the time of application, Kee did not tender 1/6 of the annual premium for the policy that was issued.

---

insured as opposed to the insurer. Thus, based on the terms of the policy and the facts of this case, Kee did not satisfy the three conditions precedent to having the policy go "in force" on the application date. Rather, the policy went "in force" on its effective date, May 5, 1986, which was ten days after the issue date./3 Because this action was filed on May 4th, 1988, it was brought within two years after the policy was "in force" and is not time-barred by the incontestability clause of the policy.

Alternatively, Kee argues that the two-year incontestable period began to run on April 25, 1986, the issue date shown on the policy. However, this position must also fail. Kee's contention that the "issue date" should control is contradicted by the clear wording of the policy. The policy indicates that the issue date is not the date at which the risk commences, but simply "the date of approval by the Home Office" of the insurance company.

Based upon all the evidence presented to the court on the motions for summary judgement, the court finds that there are no genuine issues of material fact and that Provident is entitled to summary judgement as a matter of law. It is therefore

ORDERED AND ADJUDGED that Provident's motion for summary judgement is GRANTED; Kee's motion for summary judgement is DENIED; and SUMMARY FINAL JUDGEMENT is hereby entered for the plaintiff,

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3/Ordinarily, an insured might lack the sophistication to look for the effective date on a policy and to recognize its significance. However, Kee was a general agent for Provident who prepared his own application and never protested the "effective date" of May 5th, 1986, upon receipt of the policy.

Provident Life and Accident Insurance Company, and against the Defendant, Thomas B. Kee.

DONE AND ORDERED at the United States District Court, Miami, Florida

this 15 day of June, 1990.

(S)_____
KENNETH L. RYSKAMP
UNITED STATES
DISTRICT JUDGE

Copies furnished to:
John E. Meagher, Esq.
Henry J. Hunnefeld, Esq.

EXHIBIT "F"

APPLICATION

I hereby apply to Provident Life and Accident Insurance Company for insurance based on the following representations:

1 (a) Full Name?

(Print) Thomas B. Kee et al.

. . . .

(Above the signature line is printed)
To the best of my knowledge and belief, all of the foregoing statements and all of those in Part II if any of this application are true, complete, and correctly stated. [Emphasis added.]

(Kee's mote - A copy of the complete application and medical forms as of policy binding date of February 4th, 1986 is in a Lodging with the Clerk inasmuch as it would have been impossible to reduce them to conform with the Court's Rules).

EXHIBIT "G"

THE MIAMI HERALD

SUNDAY, JUNE 10, 1990 - front page

Insurers cheat Medicare, suits claim

Some of the nation's biggest health-insurance companies are cheating taxpayers out of as much as $ 1 billion a year by side-stepping a law designed to bail out Medicare, federal investigators say.

page 20A

. . . the Justice Department filed suit 14 months ago against Provident Life and Accident Insurance Co. of Chattanooga, Tenn. The department is seeking to recover as much as $223 million from Provident.

According to the government's and Bustamonte's suits, Provident knowingly and routinely violated the Tax Equity and Fiscal Responsibility Act (1982).

"When Provident got a bill that showed Medicare had already paid primary, it would issue a check only for the secondary 20 percent."

Court files in the suits against Provident include a stack of internal memorandums that, the plaintiffs say, provide further evidence that the company knew what it was doing.

One memo, from a Provident regional manager to his boss says, "It is quite obvious to everyone that Medicare has no way of knowing who in their claim

files is an active employee. Consequently, they will never be able to track this down and pass it back to the insurance industry."

Another memo spells out Provident's policy on claims from the working aged: "Claims on which information is submitted that Medicare has paid as primary should be paid as secondary. The balance of Provident's legal liability should not be paid until Medicare requests that they be reimbursed. Under no circumstances should Provident's liability in excess of our secondary payment be paid to the provider(s) or the Medicare beneficiary."

In yet another memo a Provident employee opines those claims instructions create "a violation of federal law when we pay as secondary."

Provident has blacked out that line on the copy of the memo it turned over to Bustamonte during the pretrial discovery process. The company has also gone to court to try to prevent the writer of the memo from testifying before the Senate subcommittee.

Other Provident memos indicate that the company was keeping logs of Medicare-paid claims that should have been paid by Provident. When litigants requested those logs the company said they had been destroyed.

Of the five companies (Provident, Prudential, Jefferson-Pilot, Blue Cross and Blue Shield, and Pan-American) sued by Bustamonte, Justice has filed suit against only Provident.

(Kee's note - The complete article will be found in a Lodging with the Clerk).